Oregon Department of Human Services
Office of Aging and People with Disabilities
Oregon Administrative Rules

Chapter 411
Division 027

Payment Limitations in Home and Community-Based Services

411-027-0000

(Renumbered to OAR 411-027-0020, 06/01/2008)

411-027-0005 Definitions

(Temporary effective 01/01/2026 through 06/29/2026)

(1) "AAA" means "Area Agency on Aging" as defined in this rule.

(2) "Activities of Daily Living (ADL)" mean those personal, functional activities required by an individual for continued well-being, which are essential for health and safety. Activities include eating, dressing and grooming, bathing and personal hygiene, mobility, elimination, and cognition.

(3) “Adult Foster Homes (AFH)” mean any facility licensed under OAR chapter 411, divisions 049, 050, 051, 052, OAR chapter 411, division 360 or OAR chapter 309, division 040.

(4) "Aging and People with Disabilities (APD)" means the program area of Aging and People with Disabilities, within the Oregon Department of Human Services.

(5) "Area Agency on Aging (AAA)" means the Department designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to older adults and adults with disabilities in a planning and service area. The term Area Agency on Aging is inclusive of both Type A and Type B Area Agencies on Aging as defined in ORS 410.040 and described in ORS 410.210-300.

(6) "Assessment" or "Reassessment" means an assessment as defined in OAR 411-015-0008.

(7)” Assisted Living Facility” means a building or complex that is licensed by the Oregon Department of Human Services per OAR chapter 411, division 054 rules.

(8) "Assistive Devices" means any category of durable medical equipment, mechanical apparatus, electrical appliance, or instrument of technology, service animals, general household items, or furniture used to assist and enhance an individual's independence in performing any activity of daily living.

(9) “Behavior Support Plan” means a plan written by a department approved Behavior Support Services professional to write plans detailing how the licensed provider should respond to an individual’s behavior(s) and/or how to prevent behaviors.

(10) “Caregiver” means any person paid to provide services and supports related to Activities of Daily Living, Instrumental Activities of Daily Living and health related tasks.

(11) "CA/PS" means the "Client Assessment and Planning System" as defined in this rule.

(12) "Case Manager" means an employee of the Department or Area Agency on Aging, who assesses the service needs of an applicant, determines eligibility, and

offers service choices to the eligible individual. The case manager authorizes and implements the service plan and monitors the services delivered.

(13) "Central Office" means the unit within the Department responsible for program and policy development and oversight.

(14) "Client Assessment and Planning System (CA/PS)":

(a) Is the single entry data system used for --

(A) Completing a comprehensive and holistic assessment;

(B) Surveying an individual's physical, mental, and social functioning; and

(C) Identifying risk factors, individual choices and preferences, and the status of service needs.

(b) The CA/PS documents the level of need and calculates the individual's service priority level in accordance with the rules in OAR chapter 411, division 015, calculates the service payment rates, and accommodates individual participation in service planning.

(15) "Consumer Choice" means an individual has been informed of alternatives to nursing facility services and has been given the choice of institutional services, Medicaid home and community-based service options, or the Independent Choices Program.

(16) "Contracted In-Home Care Agency" means an incorporated entity or equivalent, licensed in accordance with OAR chapter 333, division 536, that provides hourly contracted in-home services to individuals served by the Department or Area Agency on Aging.

(17) "Cost Effective" means being responsible and accountable with Department resources. This is accomplished by offering less costly alternatives when providing

choices that adequately meet an individual's service needs. Those choices consist of the available services under the Medicaid home and community-based service options, the utilization of assistive devices, natural supports, architectural modifications, and alternative service resources (defined in OAR 411-015-0005) not paid for by the Department.

(18) "Department" means the Oregon Department of Human Services (ODHS).

(19) "Distressed Provider Relief Fund" means the program described in OAR chapter 411, division 029 designed to provide additional compensation to providers who meet the criteria.

(20) "Enhanced Wage Add-on Program" means the program described in OAR 411-027-0160 designed to provide additional compensation to providers who meet the criteria.

(21) "Exception" means a Department approved payment, rate or authorized hours based on the Department’s determination that the individual’s service needs exceed those assumed in the rate methodologies including the minimum hours of care defined in the payment tiers or specific needs contract.

(22) "Homecare Worker" means a provider, as described in OAR 411-031-0040, that is directly employed by a consumer to provide hourly services to the eligible consumer.

(a) The term homecare worker includes consumer-employed providers in the Spousal Pay and Oregon Project Independence Programs. The term homecare worker also includes consumer-employed providers that provide state plan personal care services to older adults and adults with physical disabilities. Relatives providing Medicaid in-home services to an individual living in the relative's home are considered homecare workers.

(b) The term homecare worker does not include Independent Choices Program providers or personal care attendants enrolled through the Office of Developmental Disability Services or the Addictions and Mental Health Division.

(23) "Hourly Services" mean the in-home services, including activities of daily living and instrumental activities of daily living, that are provided at regularly scheduled times.

(24) "Independent Choices Program (ICP)" means the self-directed in-home services program in which a participant is given a cash benefit to purchase goods and services identified in a service plan and prior approved by the Department or Area Agency on Aging.

(25) "Individual" means the person applying for, or eligible for, services. The term "individual" is synonymous with "client", "participant", "consumer", and "consumer-employer."

(26) "In-Home Services" mean those services that meet an individual's assessed need related to activities of daily living and instrumental activities of daily living provided in the individual’s home or family’s home.

(27) "Instrumental Activities of Daily Living (IADL)" mean those activities, other than activities of daily living, required by an individual to continue independent living. The definitions and parameters for assessing needs in IADL are identified in OAR 411-015-0007.

(28) "Natural Supports" or "Natural Support System" means resources and supports (e.g., relatives, friends, significant others, neighbors, roommates, or the community) who are willing to voluntarily provide services to an individual without the expectation of compensation. Natural supports are identified in collaboration with the individual and the potential "natural support". The natural

support is required to have the skills, knowledge and ability to provide the needed services and supports.

(29) "Rate Schedule" means the rate schedule maintained by the Department in OAR 411-027-0170 and posted at https://www.oregon.gov/odhs/providers-partners/seniors-disabilities/Documents/rate-schedule.pdf.

(30) “Residential Care Facility (RCF)” means a building or complex that is licensed by the Oregon Department of Human Services per OAR chapter 411, division 054.

(31) "These Rules" mean the rules in OAR chapter 411, division 027.

(32) “Tier” refers to the rate level assigned to an eligible individual in an Adult Foster Home or Residential Care Facility, based on their assessed need. Tiers are determined using a point system evaluating the individual’s ability to perform each component of Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs) and health-related tasks as documented in the CA/PS assessment.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-027-0020 Payment Limitations in Home and Community-Based Services

(Amended 03/29/2018)

(1) Payment for Services.

(a) Service payments under these rules are limited to services provided under Oregon's Medicaid State Plan K Option for individuals served through the Department’s Aging and People with Disabilities program area.

(b) Home and community-based services include, but are not limited to:

(A) In-home services (consumer-employed providers and contracted in-home care agencies).

(B) Residential care facility services.

(C) Assisted living facility services.

(D) Adult foster home services.

(E) Specialized living services.

(F) Adult day services.

(G) Home-delivered meals.

(2) Payment Basis.

(a) Unless otherwise specified, service payment is based upon an individual's assessed need for services as documented in CA/PS.

(b) Payments for home and community-based services are not intended to replace the resources available to an individual from the individual's natural support system. The Department may authorize paid services only to the extent necessary to supplement potential or existing resources within an individual's natural supports system.

(c) An individual with excess income must contribute to the cost of services pursuant to OAR 461-160-0610 and OAR 461-160-0620.

(d) Service plans are based upon less costly means of providing adequate services consistent with consumer’s assessed need and choice.

(e) An individual's progress is monitored by Department or AAA local office staff. When a change occurs in the individual's service needs that may warrant a change in the service payment rate, staff must update the service plan.

(3) Service Payments. All service payments must be prior authorized by the Department or AAA local office staff.

(a) Department and AAA case managers authorize service payments from the rate schedule based on an individual's service program and assessed need for services documented in CA/PS.

(b) Any rate that differs from the rate schedule must be pre-authorized by the Central Office.

(4) Rate Schedule. Services are paid at the rate in the Rate Schedule at the time of the service. The rate schedule must be updated:

(a) When there is an increase in a rate on the schedule; or

(b) Thirty (30) days prior to when any rate is reduced.

(5) Spousal Services. The Department does not make direct payments to a spouse for providing community-based services except for in-home services as described in OAR chapter 411, division 030.

(6) Payments for Adult Day Services.

(a) Payments to any Medicaid-contracted adult day services program, as described in OAR chapter 411, division 066, are authorized by Department or AAA local office staff and made in accordance with the rate schedule.

(b) Adult day services may be authorized as part of an overall plan of services for service-eligible individuals and may be used in combination with other community-based services if adult day services are the appropriate resource to meet an identified need.

(c) Department, or AAA local office staff, may authorize adult day services for payment as a single service or in combination with other home and community-based services. Adult day services are not authorized or paid for if another provider has been authorized payment for the same service.

Payments authorized for adult day services are included in computing the total cost of services.

(d) The Department pays for a half day of adult day services when four or less hours of services are provided, and pays for a full day of adult day services when more than four, but less than 24 hours are provided.

(7) Payment for Home Delivered Meals.

(a) Payments to any Medicaid-contracted home delivered meals provider as described in OAR chapter 411, division 040 are authorized by Department or AAA local office staff and made in accordance with the rate schedule.

(b) Medicaid home-delivered meals may be authorized as part of an overall plan of services for service-eligible individuals and may be used in combination with other in-home services if meals are the appropriate resource to meet an identified need.

(8) Payments to Assisted Living Facilities. Payments to any Medicaid-contracted assisted living facility (ALF) as defined in OAR 411-054-0005 are authorized by Department or AAA local office staff and made in accordance with the rate schedule.

(a) The monthly service payment for an individual receiving services in an ALF is based on the individual's degree of impairment in each of the six activities of daily living as determined by CA/PS and the payment levels described in paragraph (c) of this subsection. The individual's initial service plan must be developed prior to admission to the ALF and must be revised if needed within 30 days. The individual's service plan must be reviewed and updated at least quarterly or more often as needed as described in OAR 411-054-0034.

(b) Activities of daily living are weighted for purposes of determining the monthly service payment as follows:

(A) Critical activities of daily living include elimination, eating, and cognition and behavior.

(B) Less critical activities of daily living include mobility, bathing, personal hygiene, dressing and grooming.

(C) Other essential factors considered are medical problems, structured living, medical management, and other needs.

(c) Payment (Impairment) Levels.

(A) Level 1 -- Service priority level 1-13 eligible individuals are qualified for Level 1 or greater.

(B) Level 1 -- Service priority level 14-17, but would require institutionalization without supports within 30 days if authorized by Central Office.

(C) Level 2 -- Individual requires assistance in cognition and elimination, mobility, or eating.

(D) Level 3 -- Individual requires assistance in four to six activities of daily living or requires assistance in elimination, eating, and cognition.

(E) Level 4 -- Individual is full assist in one or two activities of daily living or requires assistance in four to six activities of daily living plus assistance in cognition.

(F) Level 5 -- Individual is full assist in three to six activities of daily living or full assist in cognition and one or two other activities of daily living.

(d) The reimbursement rate for Department individuals receiving Medicaid services shall not be more than the rates charged by private paying individuals receiving the same type and quality of services.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-027-0025 Payment for Residential Care Facility and Adult Foster Home Services

(Temporary effective 01/01/2026 through 06/29/2026)

The Department reimburses for services provided to individuals residing in a residential care facility or an adult foster home according to the following:

(1) Service Payment. The provider must agree to accept an amount determined pursuant to OAR 461-155-0270 for room and board and a service payment determined by the Department pursuant to OAR 411-027-0020 or 411-027-0050 as payment in full for all services rendered to an individual.

(2) Unless otherwise specified in this rule, a tiered rate model is paid for all eligible individuals in accordance with the rate schedule or collective bargaining agreement.

(3) Service Rates. Service rates are based on an individual's assessed need for services as documented in CA/PS. Service eligibility levels are assigned based on the degree of assistance an individual requires with activities of daily living, instrumental activities of daily living, health related tasks and other activities that must be performed by a provider.

(4) Acuity-Based Rate Model.

(a) Adult Foster Homes and Residential Care Facilities will receive payments based on an Acuity-Based Rate Model. The Acuity Based Rate Model is based on an individual’s assessed level of need in Activities of Daily Living (ADLs),

Instrumental Activities of Daily Living (IADLs), cognition, behavior, and health related treatment need as determined by the CA/PS assessment. Each component of the ADL and IADL shall receive points based on the following assessed level of need:

(A) Independent equals 1 point

(B) Minimum Assist equals 2 points

(C) Assist equals 3 points

(D) Substantial Assist equals 5 points

(E) Full Assist equals 6 points

(F) Additional points shall be assigned based if either of the following criteria is met:

(i) Full assist in the components of self-preservation, decision-making, or ability to make self-understood equals 10 points.

(ii) Substantial or full assist in the component of challenging behaviors equals 20 points.

(iii) An individual who meets the criteria in (ii), will only receive an additional 20 points. The points awarded in (i) and (ii) are not combined.

(iv) Complex health related treatment tasks, as documented in the individuals CA/PS, that requires caregiver assistance on a regular basis but less than once per day equals 1 point.

(v) Complex health related treatment tasks, as documented in the individuals CA/PS, at least daily and requires caregiver assistance each time equals 3 points.

(b) Individuals will receive points for complex health related treatments and tasks, as defined by the Department. Complex health related tasks that occur at least weekly will receive 1 point, while complex health related tasks that occur at least daily receive equal three points.

(c) Individuals will be placed on payment tiers based on their total score. Tiers are assigned based on the following scores:

(A) Tier 1 equals 0 to 40 points.

(B) Tier 2 equals 41 to 55 points.

(C) Tier 3 equals 56 to 82 points.

(D) Tier 4 equals 83 -106 points.

(E) Tier 5 equals 107 or more points.

(d) Funded Caregiving Hours. For Adult Foster Homes each tier funds one caregiver on duty 24 hours a day and funds additional caregiving hours per day for each individual as follows:

(A) Tier 1 equals 0 hours.

(B) Tier 2 equals 2 hours.

(C) Tier 3 equals 4 hours.

(D) Tier 4 equals 8 hours.

(E) Tier 5 equals 10 hours.

(e) An individual who is eligible for Extended Waiver Eligibility, as defined and authorized in OAR 411-015-0030, is only eligible for Tier 1 payments.

(5) Payment Responsibilities.

(a) An individual is entitled to retain a personal allowance plus any income disregards pursuant to OAR 461-160-0620.

(b) An individual is responsible for payment of the room and board amount pursuant to OAR 461-155-0270.

(A) An individual eligible for Medicaid under OAR chapter 410, division 200 and eligible for long term care services under OAR 411-015-0100 living in community-based care facilities may be eligible for room and board assistance if the individual's gross income is less than the room and board amount defined in OAR 461-155-0270. The Department issues a special needs payment to the facility, on the individual's behalf, for the difference between the individual's income and the room and board standard.

(B) An individual eligible for Medicaid under OAR chapter 410, division 200 and receiving room and board assistance must apply for all benefits for which the individual may be eligible, per OAR 410-200-0220, to continue to receive the room and board assistance. Individuals must follow all appeal options if applicable.

(c) An individual must contribute any income in excess of the personal allowance, income disregards, and room and board payments to the provider toward the service payment pursuant to OAR 461-160-0610 and OAR 461-160-0620.

(d) The Department issues payment to the provider for the difference between the service payment and the available income of the individual.

(6) The provider may not charge the individual, a relative or a representative of the individual, any other costs except for the room and board and a client contribution payments, if applicable.

(7) The Department is not responsible for damages to the provider's home, facility or property, or obligations entered into with the individual.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-027-0050 Exceptions to Payment Limitations in Home and Community-Based Services

(Temporary effective 01/01/2026 through 06/29/2026)

(1) Eligibility for Exceptions.

(a) Exceptions for in-home services as defined in OAR 411-030-0020 are not subject to this rule.

(b) Exceptions will only be granted when the requirements of this rule are met and the provider submits all requested documentation, as required by this rule verifying that additional caregiving was delivered to each current Individual as funded by their respective Tiers and exceptions.

(c) Exceptions authorized by this rule shall only be provided to Individuals living in the following licensed settings:

(A) Adult Foster Homes; or

(B) Residential Care Facilities, including Intensive Intervention Communities; or

(C) Licensed 24-hour residential programs as defined in and licensed in accordance with OAR 411-325-0020 (1) and (2); or

(D) Residential Treatment Homes or Residential Treatment Facilities as defined and licensed in accordance with OAR 309-035-0105 (77) and (78).

(e) Exceptions are not allowed for:

(A) Individuals served under a specific needs contract(s) unless the Department has determined a specific Individual has care needs that require additional staff hours beyond what is provided by the contract;

(B) Assisted Living Facilities;

(C) Any individual served under an Intensive Individual Rate.

(D) Nighttime care needs that fall outside of regular or anticipated routines. Occasional night needs are not eligible for an exception.

(E) Anticipatory or just in case needs.

(f) The amount of any approved exception is based on the additional Caregiver staff hours required to meet the Individual's assessed and verified ADL, IADL, health related tasks, or behavioral needs per OAR chapter 411, division 15 that exceed the service expectations in licensing rules and all the hours funded by Individuals' assigned Tier.

(g) Exceptional hours may be approved to monitor the Individual when they have a history of physically or sexually harming others and there is a documented likelihood that the Individual could harm themselves or others in the immediate future.

(h) At the sole discretion of the Department, an exception may be granted without required documentation if an individual is in an unsafe or dangerous situation. Such exception may not exceed 90 days. Providers must submit the required documentation within that time period, or the exception will end. Documentation may include, but is not limited to:

(A) Documentation of medical conditions or treatments that may drive care needs;

(B) Medical documentation that the way services are being provided is appropriate to the needs of the Individual;

(C) Documentation from medical professionals, a Long-Term Care Community Nurse or a Behavior Support Specialist that reflect the needs that meet exceptional criteria;

(D) The reasons for increased duration and frequency of care need or health related tasks;

(E) Other information explaining or related to the need for additional hours; and

(F) Diagnosed psychiatric conditions, period(s) of institutionalizations or other documented behavioral health history that demonstrates the Individual poses a current threat or the high likelihood that the Individual will pose a threat of harm to themselves, the community, other Individuals in the facility, the provider and/or caregivers.

(G) Past criminal charges with period(s) of incarcerations, that demonstrates the Individual poses a current threat or the high likelihood that the Individual will pose a threat of harm to themselves, the community, other Individuals in the facility, the provider and/or caregivers.

(i) For Adult Foster Homes, exceptions are limited to needs that exceed the level of staffing required by the Individual's tier and requires:

(A) One-to-one assistance or supervision for a significant amount of time to manage behavioral care needs or other ADL tasks;

(B) Two or more staff to provide ADL task assistance to the Individual at the same time;

(C) Additional frequent monitoring due to a history in the last 90 days of behaviors that currently endanger the individual, other Individuals in the facility, the community and/or caregivers and there is a likelihood of harm to the Individual or other Individuals;

(D) To meet ongoing care needs of the Individual that occur during sleeping hours. Exceptions approved for night needs will not exceed 8 hours per individual for a 24-hour period and may be reduced when there are multiple individuals requiring night care and the care needs of all Individuals in the facility can be met by one awake caregiver;

(E) Additional staff to assist with ADL, IADL or health related tasks due to the Individual experiencing false memories that has resulted in inaccurate or distorted reporting of events and leading to multiple false allegations of abuse or criminal acts against others.

(j) Exceptions for more than one Individual in a facility will only be allowed if:

(A) The exception request meets the requirements in these rules.

(B) The information provided indicates the assessed needs of each individual are independently documented in the individual's person-centered service plan.

(C) The provider has supplied evidence they can and will provide the staffing for all the required staffing in the tiers for their current Individuals and approved exception hours in the home. This evidence may include but is not limited to, staffing plans and payroll records.

(k) Exceptions will not be approved when:

(A) Proposed services are not based on the Individual's assessed service needs, except as otherwise provided in these rules;

(B) Proposed services are not medically appropriate or necessary as determined by a qualified medical professional;

(C) Proposed services would violate licensing regulations applicable to the provider's license or certification;

(D) Proposed services include activities or instrumental activities of daily living not allowed in OAR 411-015-0006 and 411-015-0007;

(E) Proposed services are not covered in the 1915(k) State Plan, OAR 411-015-0006, or OAR 411-015-0007;

(F) Proposed tasks are not allowed in OAR 411-015-0006 and OAR 411-015-0007 unless identified in the Individual's behavior support plan; or directed by a qualified medical professional;

(G) Proposed exception request includes building utilities, food, or, building maintenance costs;

(H) Proposed services address needs that do not require additional caregiver hours or not documented in the individual's CA/PS;

(I) Proposed hours or services include supplementing the income for the provider, owners or investors of the facility or are not directly related to the need for additional care;

(J) Proposed services are to provide wages to caregivers beyond the established hourly wage for exceptions;

(K) Proposed services are based solely on fire evacuation needs;

(L) The exceptional need could be provided by durable medical equipment or other community resources;

(M) Staffing plans and payroll records indicate the exceptional hours are being provided concurrently to other Individuals, based on their Tier, to other approved exceptions or other required staffing;

(N) Proposed services are meant to provide companionship hours;

(O) Proposed services are to monitor the Individual unless the reason for monitoring is otherwise allowed in the rules; or

(P) The provider fails to provide sufficient payroll documentation and staffing schedules, as required by this rule, that demonstrates they have been providing staffing as required in each of the Individual's tier and each Individual's exception as applicable.

(2) INITIATION OF AN EXCEPTION REQUEST.

(a) A request for an exception may be initiated by the provider, the Individual, or the Individual's representative.

(b) A request for an exception may be initiated either orally or in writing by an Individual or the Individual's representative to their case manager. An exception request initiated by an Individual or their representative can only be considered once the provider submits the required documentation requested by Department.

(c) All exception requests regardless of requestor must include:

(A) How the Individual's assessed needs or documented safety needs exceed the staffing levels provided by the assessed rate and minimum staffing levels required by staffing expectations in the relevant licensing administrative rules.

(B) The request must be in writing and include the Department assessment calculator that documents the amount of time it takes to complete each task the exceptional hours would support.

(C) The specific ADL(s), IADL(s), health related task or behavioral need for which the exception is being requested.

(D) A written staffing plan is submitted from the adult foster home provider that demonstrates they do provide sufficient caregiver hours for the Individual's request, any other exceptions in the adult foster home and Tier staffing for all Individuals in the home. The staffing plan must include an attestation from the provider that the staffing plan is true, accurate and the provider intends to provide the additional caregiver hours.

(d) Requests with incomplete information, incomplete documentation or information that doesn't support the exception request will be denied and returned to the requestor as a denial.

(e) The Department may require additional information to be submitted by the provider prior to making a decision. This information may include, but not limited to:

(A) The Individual's service plan or Care Plan;

(B) Medical Records;

(C) Existing and proposed staffing plan/schedule;

(D) Payroll records that show the provider is appropriately staffing hours required by the Individuals' assigned Tier and all existing exceptions in the facility as applicable.

(E) Home health or hospice reports if available;

(F) Long Term Care Community Nursing (LTCCN) or other nursing assessments and notes, if available; and

(G) A Behavior Support Plan completed by a Department contracted Behavior Support Specialist if the exception is based on behavioral needs.

(f) An exception request will be denied and returned to the requestor if the additional documentation is not submitted by the date specified in writing by the Department.

(3) PROCESSING EXCEPTION REQUESTS.

(a) Prior to forwarding any request for an exception to the Department's APD Central Office, the case manager must discuss with the requestor whether there are alternate ways to meet the Individual's needs consistent with the Individual's right to independence and choice. This discussion must be documented in the Oregon Access Narration.

(b) After discussing alternative ways to meet the Individual's needs, and the requestor wishes to continue with the exception request, the case manager will forward the exception request to their manager for review and approval. Once approved, the manager will forward the request to the Department's APD Central Office for a decision.

(c) The CA/PS assessment must represent the Individual's current condition and functioning unless an urgent situation exists as referenced in these rules.

(d) If the CA/PS assessment does not reflect the needs described in an exception request, a new assessment will be required before the rate can be renewed unless an urgent situation exists as referenced in these rules. When there is an urgent situation, a new CA/PS must be completed and

demonstrate the Individual's needs by the date required by the Department's Central Office.

(4) The following required Documentation must be maintained by the provider and available to the Department at any time:

(a) For all approved exception requests providers must maintain the following documentation:

(A) Staffing schedules showing the dates and times each caregiver worked in the facility.

(B) For exceptions based on behaviors, the following must also be maintained:

(i) The frequency of behavioral interventions performed by caregivers, if applicable to the approved exception.

(ii) Narrative notes and care plans that demonstrate Behavioral Support Plans are implemented

(C) Payroll records, including pay stubs which show income tax withholdings, payroll tax withholdings, hours worked, pay periods, and hourly rate of pay.

(b) When the Department has concerns about the accuracy of the records submitted, when there are reports the provider has not staffed appropriately and/or when the provider has a history of not staffing exception(s), the Department may require additional documentation to ensure the exception is appropriate for the Individual or to determine if the staffing required by the exception has been provided. This documentation can include, but is not limited to:

(A) Verifiable records showing taxes were withheld and reported to the appropriate government agency.

(B) Verifiable documentation payroll taxes were paid to the appropriate government agency.

(c) Required documentation must be available to the Department at all times and provided immediately upon request unless the Department has given a different timeline.

(5) EXCEPTION DECISIONS.

(a) Only the Department's APD Central Office can approve exceptions and has final decision authority and discretion over the approval or denial of an exception.

(b) An exception may be approved temporarily with documentation requirements and/or actions the provider must implement to mitigate the need for an exception. Any required documentation or other requirements will be communicated to the provider in writing.

(c) Local ODHS offices, APD and Type B Area Agencies on Aging may deny or choose not to renew exceptions when:

(A) There is no demonstrated need for the exception;

(B) The provider fails to submit sufficient documentation to show that all exceptions within the adult foster home can be appropriately staffed.

(d) Exceptions will be approved until the Individual's current CA/PS assessment is due for renewal, or for a shorter period when:

(A) The Individual is discharging from a hospital;

(B) The exception was approved due to an urgent situation as specified in these rules;

(C) Medical records or verification from the Individual's medical or behavioral health professional indicate that the need for additional caregiving hours may be temporary;

(D) When the exception is for behavioral or cognitive needs and Individual doesn't have a behavior support plan;

(E) The provider has a history of not appropriately staffing exceptions, an Intensive Individual Rate or specific need contracts, including instances of licensing violations related to insufficient or unqualified staff;

(F) The Department determines there is reason to believe the Individual may not require the exception on a long-term basis.

(G) The Department has reports of licensing complaints or adult protective service allegations.

(H) The request for an exception renewal was not received timely.

(e) Renewals of exception requests must be requested prior to the expiration date and must include:

(A) Payroll records, staffing schedules, as specified in this rule that demonstrate the additional caregiving hours as funded by the exception were provided;

(B) Documentation as specified in OAR 411-027-0050 (2) (a) – (g);

(C) Other documentation as required by the Department.

(f) Exceptions may only be renewed when:

(A) The Individual's CA/PS assessment continues to show the need for the exception;

(B) The provider has demonstrated they have provided the additional caregiver hours as required by all Individuals' Tiers and funded by all exceptions in the facility.

(g) Exceptions may be terminated, denied or partially approved when:

(A) The documentation does not support the requested number of exceptional hours. This includes instances where the requestor did not submit sufficient evidence to allow APD Central Office to make a decision or did not complete the required forms within the timeframe set by the Department;

(B) The staffing plan does not demonstrate sufficient proposed staffing for the requested exception and other existing exceptions and Tiers in the facility.

(C) When the Individual's CA/PS assessment does not reflect the need for additional caregiving hours unless an urgent situation exists as referenced in these rules.

(D) As applicable, when the Individuals Behavior Support Plan doesn't reflect the behavioral needs or interventions as documented in the exception request.

(E) The Individual's medical documentation doesn't support the number of exceptional hours requested, when alternatives could be tried or when the verification doesn't address all of the requirements by OAR 411-027-0050 (2) (c) (D) (i) –(vi).

(F) When the Provider is not able to supply documentation as required by the Department or taken actions that could mitigate the need for an

exception.

(G) When Provider has a history of not appropriately staffing exceptions, an Intensive Individual Rate or specific need contracts, on multiple occasions. This includes instances of licensing violations related to insufficient or unqualified staff.

(h) If the exception request is partially approved, terminated or denied as described in this subsection, a written decision will be provided to the provider indicating the reasons for the action.

(i) When exception orientation training has been temporarily waived due to lack of availability or an urgent situation, as specified in these rules, the exception may be terminated if the provider does not complete the training by the date required by the department.

(j) If the Individual or the Individual's legal representative, as applicable, initiated the request, a notice of planned action will be sent to the requestor which includes contested hearing rights under ORS chapter 183 when an exception request is denied, reduced, partially approved or terminated. Hearing requests must be submitted within 30 days.

(k) If the provider initiated the request, the Department will provide a written notice that includes the following elements:

(A) The date;

(B) The name of the provider;

(C) The Department's decision; and

(D) Reason(s) for the Department's decision.

(l) The provider may request an administrative review within 14 days of receiving notice of denial, termination, or partial approval by sending a written notice to the Individual's case manager.

(m) A provider, Individual, or Individual's legal representative may submit a request to increase an exception. The request must include additional information demonstrating the need for the exception and a new CA/PS assessment has been conducted by the case manager that documents the need for the change to an exception. Requests for an increase will be treated as a new exception request.

(n) Exceptions expire at the end of the Individual's service plan authorization or at an earlier date as determined by the Department.

(o) Adult Foster Home providers will be given at least 10 business days written notice prior to the expiration or termination of an exception. Providers that do not receive this notice will continue to be paid the exception until a 10-day written notice is issued.

(p) The requestor seeking a renewal must submit the renewal request on the required forms and payroll documentation showing additional caregivers were provided as funded by the exception, prior to the exception expiration date.

(q) Failure to comply with these timelines will result in an exception expiring. If an exception expires, a new request must be completed and providers will not be paid for the period between when the exception expired and when a new exception, if approved, begins.

(r) The Department may deny an exception request, regardless of who has initiated it, when in the last three years the provider has a history of not appropriately providing sufficient staffing to meet an exception or not

providing requested documentation to the Department on multiple occasions to support an exception.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-027-0075 Special Payment Contracts

(Amended 09/02/2014)

(1) The Department may authorize three different types of special payment contract arrangements.

(a) Supplemented Program Contract. A supplemented program contract pays a rate in excess of the rate schedule to providers in return for additional services delivered to target populations.

(b) Consistent Revenue Contract. A consistent revenue contract allows a payment rate based on average facility case mix. The contracted rate is in the range allowed by the rate schedule and is based on individual needs.

(c) Specific Needs Setting Contract. A specific needs setting contract pays a rate in excess of the rate schedule to providers who care for a group of individuals all of whose service needs exceed the service needs encompassed in the base payment and all add-ons.

(2) Supplemented Program Contracts.

(a) The Department may authorize a service payment rate not included in the rate schedule for Residential Care Facilities, Assisted Living Facilities and Adult Foster Homes providing additional services to a targeted population, pursuant to a written contract with the Department. To qualify, the facility must demonstrate to the Department that:

(A) There is a documented need for additional services to the target population.

(B) The administrative and care staff have sufficient program knowledge and skills to achieve program goals and provide the additional services.

(C) The facility provides substantial additional services beyond those covered under the rate schedule.

(D) There is a comprehensive ongoing staff training program targeted to the population's needs.

(E) The facility has made any modifications necessary to provide the additional services.

(F) The Medicaid individuals served in the facility demonstrate increasing need for assistance with activities of daily living and cognitive abilities due to Alzheimer's Disease or other dementia.

(i) "Alzheimer's Disease" means a chronic, progressive disease of unknown cause that attacks brain cells or tissues.

(ii) "Dementia" means a clinical syndrome characterized by a decline in mental function of long duration in an alert individual. Symptoms of dementia include memory loss and the loss or diminution of other cognitive abilities such as learning ability, judgment, comprehension, attention and orientation to time and place and to oneself.

(G) The facility has provided the additional service for at least six months prior to the date on which the supplemented program contract takes effect. Additionally, the Department may approve

supplemented program contracts to be effective prior to the date on which the facility has provided the additional service for six months based on:

(i) The Department experience of provider ability to provide the additional service;

(ii) The recommendation of the Department and AAA local office staff; or

(iii) Unmet community need for the additional services to be offered under the contract.

(H) The facility may identify, at the time of application for the supplemented program contract, the additional costs the facility incurs to deliver the additional services. The facility shall include, at a minimum, the additional staffing and training costs it incurs as a result of delivery of the additional services.

(b) The Department must evaluate the information submitted by the facility, and may authorize a contracted payment amount.

(c) A contract may be renewed at the appropriate payment rate on an annual basis for a facility that continues to meet the criteria stated in section (1)(a) of this rule.

(A) At the time of the request for renewal, or at any other time the Department requests, the facility shall provide the Department with information on actual costs incurred in delivery of the additional services. Information provided by the facility shall be in the format prescribed by the Department and shall, at a minimum, include the costs of staffing the additional services and of training for direct care staff.

(B) The Department must evaluate the information submitted by the facility and may re-authorize a contracted payment amount.

(d) The supplemented program contract rate may be increased only if the Legislative Assembly authorizes the Department to do so and appropriates the funds needed to pay the increase.

(3) Consistent Revenue Contracts. The Department may authorize a service payment rate not included in the rate schedule for Residential Care Facilities, Assisted Living Facilities and Adult Foster Homes that request a consistent revenue rate pursuant to a written contract with the Department.

(a) In a consistent revenue contract, the Department establishes a uniform service payment rate for all individuals. The uniform service payment rate is equivalent to the average service payment rate the Department pays under the rate schedule. In no case shall the consistent revenue contract payment exceed the average amount the Department pays to the facility under the rate schedule.

(b) A provider must request a consistent revenue contract in writing. The request must include the suggested payment amount and justify the calculation of that amount by attaching copies of the most recent three full calendar months Provider Individual Summary Form.

(A) If a request for a consistent revenue contract and the required justification are received by the Department on or before the 15th of the month, the consistent revenue contract payment amount is effective for payment for services rendered on or after the first day of the month immediately following receipt of the request.

(B) If a request for a consistent revenue contract and the required justification are received by the Department after the 15th of the

month, the consistent revenue contract payment amount is effective for payment for services rendered on or after the first day of the second month following receipt of the request.

(c) A consistent revenue contract may be terminated by the facility by providing 30 days written notice to the Department. If a consistent revenue contract is terminated, service payments for individuals are made in accordance with the rate schedule.

(d) The Department may terminate a consistent revenue contract by providing 30 days written notice to the facility. If a consistent revenue contract is terminated, service payments for individuals are made in accordance with the rate schedule.

(e) Payment rates under consistent revenue contracts may be adjusted due to changes in facility case mix.

(A) The Department must review facility case mix annually at contract renewal. The determination of average facility case mix is based on the average service payment level to which the Department has assigned individuals over the three calendar months that precede the determination.

(B) Notwithstanding section (3)(e)(A) of this rule, in the first year during which a facility is paid under a consistent revenue contract, the facility may request that the consistent revenue contract payment be recalculated after six months. The request must include the recommended payment amount and justification of that amount.

(f) Service payment rate amounts paid under a consistent revenue contract are increased as a result of legislatively approved increases at the same time and in the same way as are other facilities of the same licensure.

(4) Specific Needs Setting Contracts.

(a) Specific needs settings are found in Adult Foster Homes, Residential Care Facilities and Assisted Living Facilities. These settings provide community-based care services for individuals whose needs are not met by the rate schedule.

(b) Determination of facility eligibility for a specific needs setting contract is at the discretion of the Department. In making its determination, the Department shall consider:

(A) The needs of the individuals being provided care;

(B) The availability of other community long-term care options to meet individual needs; and

(C) The proportion of facility individuals demonstrating the specific needs setting care need and other factors as the Department may determine.

(c) The provider shall submit information to the Department in the form and at the time requested in order to determine the Medicaid rate to be paid.

(d) The total rate for specific needs setting contracts shall be approved by the Department. The approved rate is a single rate paid for all Title XIX individuals with the specific needs setting care need that live in the eligible facility.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-027-0100

(Renumbered to OAR 411-027-0025, 01/01/2002)

411-027-0125 Distressed Provider Relief Fund

(Adopted 02/10/2023)

The Department may authorize a payment to a Medicaid Assisted Living Facility, Residential Care Facility or Memory Care (Endorsed Units Only) who meet the criteria described in OAR chapter 411, division 029. The Department will prioritize payments based on available funding and maintains sole authority to determine which providers will receive funding.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-027-0150 Repayment of Premium Deposits for Workers' Compensation

(Amended 09/02/2014)

Those providers on whose behalf the Department made a Workers' Compensation premium deposit in accordance with OAR 411-027-0010 (suspended 2-8-91 and repealed 5-1-91) shall repay the deposit amount to the Department at such time that the need for the deposit no longer exists. The Department shall consider the need for the deposit no longer exists when certain conditions occur. Such conditions include, but are not limited to:

(1) The provider sells, transfers, or otherwise goes out of business;

(2) The provider enters into bankruptcy;

(3) The provider's Workers' Compensation insurer no longer requires the deposit; or

(4) The Department owes monies to a nursing facility at the time of each annual settlement. Such monies shall be applied against the premium deposit amount until such time the total deposit is recovered.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-027-0160 Enhanced Wage Add-on Program

(Amended 06/29/2023)

(1) For the purposes of this rule, Home and Community Based Services (HCBS) providers refer to Assisted Living Facilities, Residential Care Facilities, Memory Care (Endorsed Units Only) and In-Home Agencies. Effective January 1, 2023, this rule includes Adult Day Services providing full day services.

(2) Establishment. The Department establishes the Enhanced Wage Add-on Program (Program). The Program is designed to support Home and Community Based Services (HCBS) providers with retention of caregivers by paying a starting wage of $15 per hour for all caregivers, with an increase to $15.50 per hour by the second year of the 2021-2023 biennium (July 1, 2022).

(3) The Department will provide additional compensation to HCBS providers who meet the criteria contained in paragraph (4). Such compensation shall be an add-on of 10% of the Medicaid rate, as authorized in OAR 411-027-0170, during the effective dates of the Program. A HCBS provider may be eligible to apply between October 1, 2021 and June 30, 2023.

(4) Criteria. Criteria must be met in order for a HCBS provider to be eligible for the Enhanced Wage Add-on Program. The HCBS provider shall submit documentation supporting that it provides a starting wage of $15 per hour or more for all caregivers, escalating up to $15.50 per hour or more by the second year of the 2021-2023 biennium (July 1, 2022). Sufficient documentation shall be submitted to the Department with the required form referenced in paragraph (6) and shall include at least one of the following:

(a) A copy of a collective bargaining agreement or addendums with such provisions;

(b) Amended policies that includes the wages for direct caregivers during the period of the Program;

(c) Notification to caregivers of wages during the period of the Program;

(d) Payroll records demonstrating rates of pay for caregivers equal to or higher than $15.50 per hour; or

(e) Written communication to staff with wage criteria that includes reference to the Legislature establishing a wage add-on to Medicaid rates for the purpose of supporting caregiver wages in partnership with the Oregon Department of Human Services, the Oregon Health Care Association, SEIU Local 503, and other senior care advocates.

(5) Payment. The Department will provide the Enhanced Wage Add-on equal to 10% of the Medicaid rate, as authorized in OAR 411-027-0170, between October 1, 2021 and June 30, 2023, for providers who meet the criteria contained in paragraph (4). The documentation of the criteria being met shall be submitted with the form by the 15th of the month for which the provider is requesting to be approved. The wage add-on rate will not be effective until the Department provides written approval to the provider.

(6) Form. HCBS providers shall submit a claim for the Enhanced Wage Add-on Program on the form created by the Department. The documentation of the criteria being met shall be submitted with the form by the 15th of the month for which the provider is requesting to be approved.

(7) Applicability. The Department will only provide the Enhanced Wage Add-on rate for services provided during the period of October 1, 2021 to June 30, 2023,

in which the provider was in compliance with the criteria contained in paragraph (4).

(8) Timeliness. Forms for the Enhanced Wage Add-on rate may be submitted during the effective dates of the Program. The documentation of the criteria being met shall be submitted with the form by the 15th of the month for which the provider is requesting to be approved.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-027-0165 Wage Transparency

(Adopted 03/25/2026)

(1) This rule is for the following providers: Assisted Living Facilities, Residential Care Facilities, Memory Care (Endorsed Units Only), Adult Foster Homes and In-Home Agencies that hold Medicaid contracts or enrolled as a Medicaid provider with the State of Oregon and serve a material number of Medicaid individuals. For this rule, a material number is defined as a provider's Medicaid census of at least 20 percent at each reporting timeline.

(2) Establishment. Per the 2025 Legislative Session, the Department is directed to collect data from the Medicaid providers referenced in Section (1) of this rule. The specific information to be collected is the average hourly base pay of direct caregivers as of June 30, 2025, and August 30, 2026.

(3) Timeliness. This is a Legislative requirement. As a requirement of all Medicaid Provider Enrollment Agreements (PEA) with the Department, all providers referenced in Section (1) of this rule must submit their responses in a format created by the Department or the Department may take action limiting the provider's ability to serve Medicaid eligible individuals. Data for the average hourly base pay of direct caregivers as of June 30, 2025, must be submitted no later than November 30, 2025. Data for the average hourly base pay of direct

caregivers as of August 30, 2026, must be submitted no later than November 30, 2026.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-027-0170 Rate Schedule for Home and Community-Based Services

(Temporary effective 01/01/2026 through 06/29/2026)

(1) Rates below are in effect starting January 1, 2026.

(2) Monthly Rates:

(a) Residential Care Facilities:

(A) Tier 1 - $2,863.00.

(B) Tier 2 - $3,421.00.

(C) Tier 3 - $3,979.00.

(D) Tier 4 - $4,537.00.

(E) Tier 5 - $5,172.00

(F) Hourly Exception Rate - $20.18 per hour.

(b) Adult Foster Homes: Rates shall be paid in accordance with the terms of collective bargaining agreements negotiated between the Service Employees International Union and the State of Oregon.

(c) Assisted Living Facilities:

(A) Level 1 - $1,980.00.

(B) Level 2 - $2,454.00.

(C) Level 3 - $3,079.00.

(D) Level 4 - $3,866.00.

(E) Level 5 - $4,649.00.

(d) Memory Care Facilities (Endorsed Units Only) - $6,346.00 per month.

(e) Contracted In-Home Care Agencies Rate - $39.40 per hour.

(f) Home Delivered Meals - $12.25 per meal.

(g) Adult Day Services - $115.24

(3) Effective July 1, 2026, to June 30, 2027, the monthly rates are as follows:

(a) Residential Care Facilities:

(A) Tier 1 - $3,482.00.

(B) Tier 2 - $4,160.00.

(C) Tier 3 - $4,839.00.

(D) Tier 4 - $5,517.00.

(E) Tier 5 - $6,290.00

(F) Hourly Exception Rate - $21.50 per hour.

(b) Adult Foster Homes: Rates shall be paid in accordance with the terms of collective bargaining agreements negotiated between the Service Employees International Union and the State of Oregon.

(c) Assisted Living Facilities:

(A) Level 1 - $2,040.00.

(B) Level 2 - $2,528.00.

(C) Level 3 - $3,172.00.

(D) Level 4 - $3,982.00.

(E) Level 5 - $4,789.00.

(d) Memory Care Facilities (Endorsed Units Only) - $6,480.00 per month.

(e) Contracted In-Home Care Agencies Rate - $40.40 per hour.

(f) Home Delivered Meals - $12.25 per meal.

(g) Adult Day Services - $122.16

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-027-0200 Personal Incidental Funds in Residential Care Facilities and Assisted Living Facilities

(Repealed 6/1/2008 See OAR 411-054)